STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	08/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSISTED LIVING AT HARTSFIELD VILLAGE	10002 COLUMBIA AVE MUNSTER, IN46321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0000	This visit was for a State Residential Licensure Survey. Survey dates: August 2, 3, & 4, 2011 Facility number: 010937 Provider number: 010937 AIM number: N/A Survey team: Janet Adams, RN Census bed type: Residential: 82 Total: 82 Census payor type: Other: 82 Total: 82 Sample: 7 These state findings are cited in accordance with 410 IAC 16.2. Quality review completed on August 9, 2011 by Bev Faulkner, RN	R0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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R0036	(k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on record review and interview, the facility failed to ensure the physician was notified of abnormal culture results for 2 of 7 residents reviewed for physician notification in the sample of 7. (Residents #3 and #5) Findings include: 1. The record for Resident #5 was reviewed on 8/2/11 at 1:15 p.m. The resident's diagnoses included, but were not limited to, congestive heart failure, high blood pressure, and a history of prostate cancer. There was a physician's order written on 7/11/11 to obtain a urinalysis. A physician's order was written on 7/21/11 to start Keflex (an antibiotic) 500 milligrams every six hours for 14 days and to repeat the urinalysis 72 hours after the antibiotic was completed. Review of the laboratory test results indicated the urinalysis was completed on	R0036	1. Prior to this observation the physicians for residents #3 and #5 had been notified and had ordered appropriate interventions.2. Potentially affected residents are identified as those who have abnormal lab results that need follow through or treatment from their physician.3. The Facility has created a new monitoring form entitled "Status Report". This form will list several topics for follow through. One of the topics will be residents who have abnormal lab results that requires physician notification. The form will be completed daily by the midnight nurse.4. The "Status Report" will be reviewed by the Administrator/Designee daily to maintain compliance. Any needed follow up or re-education will be communicated during daily report between shifts. This report will be monitored for three months.	08/23/2011

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	7/12/11. A culture of the urine was completed by the laboratory on 7/14/11. The results of the urine culture indicated the presence of greater then 100,000 Escherichia Coli (a bacteria). There was a stamp on the bottom of the above laboratory results page that indicated the report was faxed to the physician on 7/14/11 at 1:00 p.m., from the facility. The 7/11 Nurses' Progress Notes were reviewed. An entry made on 7/11/11 at 3:40 p.m., indicated the physician was faxed related to resident's complaint of back pain and possible urinalysis to be done. The next entry was made at 5:00 p.m. and indicated a new order was received for a urinalysis test to be done. There was only one entry made on 7/14/11(Thursday). This entry indicated the resident was to have an x-ray of the lumbar spine (back) and he would decide on it when he came back to the facility on Monday as the resident was going out of town until Monday. The entry also indicated the results of the above urinalysis and culture were faxed to the physician. The next entry in the Nurses' Progress Notes was made on 7/21/11 at 2:30 p.m. This entry indicated the resident returned from the physician's office with multiple			

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	orders. The next entry was made on 7/22/11 at 12:00 a.m. This entry indicated the resident was started on Keflex 500 milligrams every 6 hours for 14 days due to a urinary tract infection. When interviewed on 8/2/11 at 1:45 p.m., the facility Administrator indicated the resident was going out of town when the results came in and returned to the facility on Sunday. The Administrator indicated the resident went out to see the physician on 7/21/11 and orders were obtained then. The Administrator indicated there was no verification of the nursing staff following up on the fax sent to the physician on 7/14/11. 2. The record for Resident #3 was reviewed on 8/2/11 at 12:15 p.m. The resident's diagnoses included, but were not limited to , bronchitis, congestive heart failure, dementia, and osteoporosis. A physician's order was obtained on 6/8/11 for a stool specimen to be tested for C-Difficile (an infection). Review of the laboratory results indicated the stool specimen was collected on 6/9/11 and the final results were completed on 6/9/11. The results report also indicated the stool specimen was positive for C. Difficile Toxin and the			

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	results were phoned to (staff members name) on 6/9/11 at 2:12 p.m. The 6/11 Nurses' Progress Notes were reviewed. An entry made on 6/8/11 at 12:00 p.m., indicated orders were obtained for a stool specimen to be obtained to test for C-Difficile. An entry made on 6/9/11 at 4:30 p.m., indicated laboratory results of the positive stool for C-Difficile were faxed to the physician at this time. The entry also indicated they spoke with the nurse at the physician office who indicated the physician was out for the day. The next entry was made on 6/9/11 at 5:00 p.m. This entry indicated the resident's daughter was made aware of the results. There were no entries made on 6/10/11 or 6/12/11. The next entry in the Nurses' Progress Notes was made on 6/13/11 at 4:25 (no a.m. or p.m. marked). This entry indicated a new physician's order was obtained for the resident to receive Vancomycin (an antibiotic) 125 milligrams four times a day for 2 weeks. The facility policy titled "Laboratory Tests Processing and Reporting" was reviewed on 8/2/11 at 1:40 p.m. The Health Services Coordinator provided the current policy. There was no date on the policy. The policy indicated nurses were to monitor the receipt of the results of			

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	ordered tests and to promptly report the test results to the physician who ordered them. When interviewed on 8/3/11 at 2:00 p.m., the facility Administrator indicated the resident went to an appointment with the physician on 6/10/11. The Administrator indicated the resident's family did not leave any papers when the resident returned. The Administrator indicated she felt the resident was sent with the information of the results but could not verify if the physician was aware or any orders were given at that time.			

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R0090	(g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a			

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	notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request Based on record review and interview, the facility failed to ensure laboratory test order were obtained as ordered by the physician for 1 of 7 sampled residents reviewed for completion of laboratory tests. (Resident #1) Findings include: The record for Resident #1 was reviewed on 8/2/11 at 10:45 a.m. The resident's diagnoses included, but were not limited to, high blood pressure, diabetes mellitus, and osteoporosis. The resident was admitted to the facility on 5/27/11. There was a physician's order written on 5/27/11 for the resident to have electrolytes, BUN (blood urea nitrogen), and Creatinine lab tests completed monthly. Review of the laboratory tests results indicated the above laboratory tests were last completed on 5/31/11. When interviewed on 8/3/11 at 8:10 a.m., the facility Administrator indicated the laboratory tests were not completed monthly as ordered by the physician.	R0090	1. The physician was notified for resident #1. Lab orders for Resident #1 were entered in the lab computer for the next available lab draw date and as a monthly standing order.2. We completed a 100% audit of residents with lab orders. Using a report from our lab system and the medical charts we cross referenced lab orders to be sure labs were completed as ordered.3. The Status Report form will also include lab follow up and new lab orders to maintain compliance. (please refer to R0036 item 3)4. The Health Services Coordinator/Designee nurse will complete a 10% random sample of lab orders monthly for three months. The cross referencing method as described in item 2 will be used to complete the audit. Results of this audit will be included in Survey follow up in our Quality Assurance.	08/23/2011

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R0154	(k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation and interview, the facility failed to ensure kitchen and dining areas were clean and in good repair related to an accumulation of ice inside the freezer, freezer not operating at correct temperatures, accumulation of food spillage on ovens, stoves, and refrigerators in 1 of 2 kitchen/dining areas. (The Memory Support unit kitchen and dining areas) Findings include: 1. The dining area on the Memory Support unit was observed during the Environmental Tour on 8/3/11 at 10:45 a.m. There was an accumulation of dried spillage on top of the stove and inside the oven in the dining room area. There was dried spillage on the shelves in the refrigerator in the dining area. 2. During the Kitchen tour of the Memory Support unit on 8/3/11 at 1:45 p.m., the following was observed: a. There food spillage on the bottom of	R0154	1. The areas noted in the observation were cleaned that day. The freezer was serviced by the vendor for condensation build up.2. Residents in Memory Support could potentially be affected.3. a. Dietary staff were in-serviced on sanitation. b.A comprehensive Sanitation Checklist was created.This checklist includes cleanliness of all areas mentioned in the observation and will include monitoring the condition of the freezer, among many other items. Dietary staff members in Memory Support will be responsible for completing the checklist daily.4. Completed Sanitation Checklists will be given to the Food Service Manager/Designee. Random spot checks will be completed by the Food Service Manager/Designee weekly for three months. Staff will be re-educated or disciplined for lack of compliance.	08/23/2011

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	the microwave in the kitchen. b. There was a large build up if ice extending from the bottom of the freezer almost to the first shelf. The temperature gauge on the outside of the freezer read 34 degrees Fahrenheit. When interviewed at this time, Dietary Staff #2 indicated the freezer had been worked on a few times.			
R0155	(l) The facility shall have an effective garbage and waste disposal program in accordance with 410 IAC 7-24. Provision shall be made for the safe and sanitary disposal of solid waste, including dressings, needles, syringes, and similar items. Based on observation, record review, and interview, the facility failed to ensure used insulin syringes were contained properly for disposal related to used syringes stored in an open plastic container in 1 of 2 storage rooms observed . (The second floor storage room) Findings include: The storage room on the second floor was observed during the Environmental Tour on 8/3/11 at 11:10 a.m. There was a plastic gallon milk container on a shelf in the storage room. The plastic container	R0155	1. Residents would not be affected because they do not have access to this or other storage rooms. These areas are kept locked. Nursing staff members have access keys.2. There is no need to identify residents. (please refer to item one)3. All staff were re-educated concerning proper disposal of the residents' sharps by placing them inside the bioharzard box.4. The Administrator will monitor this storage area by unlocking the biohazard storage room to ascertain proper disposal of sharps. Monitoring will be completed weekly for three months to maintain compliance. Results of weekly monitoring will	08/23/2011

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	was filled with used insulin syringes. The container was not stored in any type of Biohazard container or box. The current facility policy titled "Waste Disposal" was received by the facility Administrator on 8/3/11 at 12:00 p.m. The policy indicated Type I wastes included needles and syringes and sharps including needles and syringes were to placed in non porous hazardous waste containers and when full were to be place in biohazard waste containers in the soiled utility room. When interviewed on 8/3/11 at 11:25 a.m., QMA #1 indicated there was one resident who disposed of the syringes in a milk carton container and then staff are to put the container in the proper box in the storage room. When interviewed on 8/4/11 at 9:00 a.m., the Administrator indicated the syringes should have been stored properly.		be included in Quality Assurance meetings for Survey follow up.	

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R0214	(a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on record review and interview, the facility failed to ensure semi-annual evaluations were completed as required for 2 of 7 residents in the sample of 7 reviewed for evaluations. (Resident #3 and #4) Findings include: 1. The record for Resident #3 was reviewed on 8/2/11 at 12:15 p.m. The resident was admitted to the facility on 3/8/2008. The resident's diagnoses included, but were not limited to, dementia, bronchitis, congestive heart failure, and osteoporosis. Review of the "Level of Needs Evaluation" form in the resident's clinical record indicated the last evaluation was completed on 3/15/10. The evaluation form indicated a functional evaluation of the resident was to be completed in writing by a licensed health care professional and an evaluation was to be performed upon admission and at least semi-annually.	R0214	1. Service Plans were updated for residents #3 and 4 after observation.2. We identify residents by the use of a monthly calendar when Service Plans are due. New residents are included in the list for service plans upon move in.3. Our system will be enhanced by assigning the Service Plan Calendar to our medical records nurse. This nurse will specifically assign Service Plans to other nurses and post the calendar each month. The Service Plans will be monitored for timely completion and for needed updates due to resident change of condition. Service Plans will be returned to the assigned nurse to update as needed. We feel confident this system will be effective in maintaining compliance.4. This system will be monitored monthly for six months by the Administrator. At the end of each month the completed calendar will be reviewed. Nurses not completing their assigned Service Plans will be disciplined. In addition the Adminstrator will randomly sample 20% of service plans for residents who have had a change	08/23/2011

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	When interviewed on 8/2/11 at 2:30 p.m., the Health Services Coordinator indicated the semi annual evaluations should have been completed by staff. 2. The record for Resident #4 was reviewed on 8/2/11 at 11:05 a.m. The resident was admitted to the facility on 9/15/2008. The resident's diagnoses included, but were not limited to, high blood pressure, bowel obstruction, and macular degeneration. Review of the "Level of Needs Evaluation" form in the resident's clinical record indicated the last evaluation was completed on 9/14/10. The evaluation form indicated a functional evaluation of the resident was to be completed in writing by a licensed health care professional and an evaluation was to be performed upon admission and at least semi-annually. When interviewed on 8/2/11 at 2:30 p.m., the Health Services Coordinator indicated the semi annual evaluations should have been completed by staff.		in condition. The results of this sample will be used to re-educate. Summary of these findings will also be included our Survey follow up in Quality Assurance.	

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R0273	(f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, record review, and interview, the facility failed to ensure foods were maintained at safe temperatures related to the condiments stored on a salad bar and opened food items in 2 of 2 kitchen areas. (The Main Kitchen and the Memory Support kitchen) Finding include: 1. The following was observed during the Kitchen Sanitation tour in the Main Kitchen on 8/2/11 at 9:30 a.m.: a. There was an opened bag of veggie patties in the cooler. b. There was an open bag of flour and an opened bag of breading mix stored in uncovered bins in the dry storage area. When interviewed at this time, Dietary Staff #1 indicated the above items should have been contained. 2. The kitchen on the Memory Support unit was observed on 8/3/11 at 1:45 p.m. There was salad bar cooler in the kitchen. The lid on the top of the cooler was	R0273	1. The Veggie patties were discarded the day of the observation and the items in dry storage were put in closed containers.2. Residents/staff being served from the kitchen could potentially be affected. The Dietary staff was in-serviced on food safety, proper food storage, and food temperatures for both hot and cold food items.3. Our system will be enhanced by the use of a new checklist for the Memory Support Steam Table. This checklist will be used to record cold food temperatures that are in the salad cooler. This new checklist was specifically created to monitor the steam table and the salad cooler. Dietary staff will complete the checklist daily.4. The Food Service Manager/Designee will randomly spot check the steam table and salad cooler weekly for three months to maintain complance. Dietary staff will be re-educated or disciplined for lack of compliance.	08/23/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	08/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSISTED LIVING AT HARTSFIELD VILLAGE	10002 COLUMBIA AVE MUNSTER, IN46321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	opened. There were several metal containers of items including, cheese slices, salad dressing, mayonnaise and tartar sauce. The temperature of the following food items were as follows: Mayonnaise: 60.7 degrees Fahrenheit Tartar sauce: 56.6 degrees Fahrenheit Ranch dressing: 60 degrees Fahrenheit Cheese: 54.8 degrees Fahrenheit Dietary employee #2 was interviewed at this time. The Dietary employee indicated she was currently the change staff in this kitchen. The Dietary employee indicated she did not check the temperatures of the items on the salad bar cooler and logs were not kept of the temperatures. She indicated she covers the items that are out during the day when her shift ends around 3:30 p.m. The Dietary employee was unable to identify the proper temperature the items were to be maintained at. Title 410 IAC 7-24 of the "Retail Food Establishment Sanitation Requirements" (effective 11/13/2004) was reviewed. Section 187 related to Potentially Hazardous Food: Hot and Cold Holding indicated potentially hazardous foods were to be held at a temperature of forty one (41) degrees Fahrenheit or less. When interviewed on 8/3/11 at 2:30 p.m., the Food/Beverage Manager indicated			

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	items should be maintained at the proper temperatures.			
R0300	(4) Over-the-counter medications, prescription drugs, and biologicals used in the facility must be labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date. Based on observation, record review, and interview, the facility failed to ensure a vial of Tuberculin Purified Protein Derivative was labeled with the date it was first opened to ensure the solution would be discarded 30 days after opening as per the manufacturer guidelines for 1 Tuberculin vials stored in 1 of the 2 Medication storage rooms observed. (The Memory Support unit Medication room) Finding include: The medication room in the Memory Support unit was observed on 8/3/11 at 3:00 p.m. There was a vial of Tuberculin Purified Protein Derivative in a box stored in the refrigerator. The vial had been opened. The date the vial was first opened was not on the vial or the box. The pharmacy label indicated it was delivered to the facility on 6/1/11. The manufacturer's information pamphlet inside the box indicated vials in use for more than 30 days should be discarded	R0300	1. The Tuberculin (TB) vial was dispositioned after the observation.2. Either staff or residents could potentially be affected if the solution was used for their annual TB testing. Only one staff member had been administered a TB test from the vial found undated.3. Reminder notices will be placed on the front of the medication refrigerators to maintain compliance.4. The Pharmacy consultant will monitor the refrigerators during her visits every other month for six months. Results of her audit will be included in our Survey follow up for Quality Assurance.	08/23/2011

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	due to possible oxidation and degradation which could affect potency. When interviewed at this time, the Memory Support Manager indicated the vial should have been dated when it was first opened. The manager indicated a total of 23 residents currently resided on the unit.			